



Montana
STATEFUND
P.O. Box 4759
Helena, MT 59604-4759

First Report

Fax: 406-444-5963
Voice: 800-332-6102

Adjuster Date Stamp

Worker

Dept Code: _____

Last Name		First Name		M.I.	Date of Birth		Social Security Number		
Home address				City		State	Postal Code		
Phone Number		Education <input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School		Gender <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Not Married <input type="checkbox"/> Unknown		Number of Dependents 3	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	Date / Amount	2	Date / Amount	3	Date / Amount	4	Date / Amount	
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer		Number of days worked per week: 5		Wage: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other: <input type="checkbox"/> Day <input type="checkbox"/> BI-weekly <input type="checkbox"/> Year					
In addition to gross earnings cited above worker received: <input type="checkbox"/> Board & Room <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:				Estimated value if any:		Is sick leave available? Used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
Worked next scheduled shift <input type="checkbox"/> Yes <input type="checkbox"/> No		Off work more than 4 work days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		Date Last Worked		Date of Return to work		Full wages paid for date of Injury? <input type="checkbox"/> yes <input type="checkbox"/> No	
								Salary continued? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Accident Description

Description of Accident (Limited to 1269 characters; continue on separate sheet if necessary)							
Cause of Injury		Part of Body		Nature of Injury		Date and Time of Injury	
Date disability began:		Date of Death:		Occupation:		Names of witnesses:	
Accident on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accident address or location: City: State: MT Postal code:					
Date employer notified:		Accident reported to:				Safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						Safety equipment used? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical

Attending Physician's Name		Address		State MT	Postal Code -	Phone Number () -	
Hospital Name		Address		State MT	Postal Code -	Phone Number () -	
Type of initial medical treatment received: <input type="checkbox"/> No treatment <input type="checkbox"/> Emergency room <input type="checkbox"/> Treatment on-site by employer or medical Staff <input type="checkbox"/> Clinic/Dr. Office <input type="checkbox"/> Hospital							

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned.

Signature of Injured Worker or Beneficiary:

Date:

Employer

Employer Name Department of Corrections		Doing Business as: Corrections		Federal Employer Identification Number (tax I.D.) 81 - 0302402				
Mailing Address PO Box 201301		City Helena		State MT	Postal Code 59620-1301	Phone Number (406) 444 - 0439		
Location of operation, if different from mailing address:				Nature of Business or SIC Code: 9111		Self-Insured? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company		Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> A member of the employer's (sole proprietor or) family living in the employer's household. <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company						
Do you have any reason to question this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain fully. Use separate sheet if you need additional space.					Was worker injured while in your employ? <input type="checkbox"/> yes <input type="checkbox"/> no	
Insurance Agent's Name		Insurance Agency			Agent's Telephone Number () -			
Prepared by:		Official title:				Date:		
Payroll Classification Code under which you report employee's wages:		Authorized Employer's Signature _____ Date: _____						